Promoting health and well-being for older people: professionals’ perspectives

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Presentation

- Background to WISH study
- Overview of the WISH study
- Findings from interviews with service providers
- Key Messages
Background
Great Expectations: Proactive care: experience up to 1990

Health promotion trials for older people in US, UK & Denmark up to 1990 showed:

- A rise in morale
- Increased referrals to all agencies
- Reduced duration of in-patient stay (sometimes)
- Increased in-patient rates (mostly respite care)
- Reduction in mortality in some trials
- No improvement in functional ability
- GP workload increased unless alternative services were organised

In practice...more recent studies of proactive care:

- MRC UK trial: little impact on quality of life or health outcomes

- ProAge study: no change in health risk behaviours

- Expectations that case management would reduce hospital admission rates for frail older people not met

- Integrated care pilots & POPPS had equivocal results

- Limited evidence of effectiveness of targeted, home-based, nurse-led interventions
Known unknowns

- Unclear what are the effective ingredients of these proactive interventions
- Unclear whether they will work in the NHS
- No real sense of the cost-benefit of proactive care
Policy context in England

Shared cross-government commitment to create a new culture of co-operation and co-ordination between care sectors ...........

- The National Collaborative for Integrated Care (May 2013)
WISH Study Overview

Study design

• Feasibility study, 2 diverse localities

• 5 General practices in London Borough of Ealing and Hertfordshire

• Invited older people (65+ years) to take part in ‘health and well-being questionnaire’ (MRAO) with a feedback report and practice follow-up
Participation

• 527/1550 (34%) of older patients agreed to take part

• Of these 454/527 (86%) completed postal questionnaires at baseline

• Follow-up: 90% completed follow-up at 3 months, 77% at 6 months

• Questionnaires were completed fully
## Stakeholder Characteristics

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<thead>
<tr>
<th>Stakeholder Type</th>
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<tr>
<td>Healthcare Professionals</td>
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Findings for services: feasibility, acceptability, utility
Integration into routine clinical care

- Practices developed systems for dealing with new needs
- Follow-up was led by practice nurse (4) or salaried GP (1)
- 19.4% of people on average were actively followed up by their practice nurse or GP
- This was feasible where there was someone with time to review and act on reports.
Integration into routine clinical care

Qualitative data suggests:

• The reports yielded some new and useful information

• The process was feasible to implement

• Some changes to care have resulted
Integration into routine clinical care

Example

- High levels of pain and incontinence reported
- Healthcare professionals did not expect these problems would be so prevalent in older people who, in general, did not have complex needs
Pain (reported by 70% of respondents)

• “That was really shocking. So many elderly people suffer pain in silence... I know from our sort of engagement with the Intermediate Care Centre locally that it is a big issue finding something that’s effective, but doesn’t actually cause more problems.”

{Healthcare Professional 5}
Incontinence (reported by 25% of respondents)

• “I don’t often discuss continence with people, so that was interesting because it’s obviously something that worries quite a lot of people but they don’t necessarily always want to present with it or talk about it” {Healthcare Professional 4}

• “I suspect that sometimes things have to get very bad before they actually come and ask for help... if we’re not being proactive in asking those questions, then we’re often not going to know” {Healthcare Professional 5}
Non-health related matters

• Support for health matters was straightforward

But...

• Identifying agencies to help with social problems was more problematic

• Healthcare professionals admitted limited knowledge of local provision for social problems
• “I remember thinking, gosh, this is opening up a whole new area that a lot of GPs and staff perhaps wouldn’t necessarily tackle at all, or know how to.” (Voluntary Sector Manager 1)

• “I don’t feel I’m that knowledgeable about local organisations.” (Healthcare Professional 7)

• “I wouldn’t have had a clue. I’d have probably gone and asked our secretary about Social Services; I wouldn’t know.” “I’ve got that [signposting service details] thing up there now! So I’ve used that quite a bit since actually with certain people.” (Healthcare Professional 8)
Aggregated Data

• Much interest in findings of local profiles

“I was just sort of thinking, oh, there’s so much in here, and the potential is so powerful” (Voluntary Sector Manager 4)

“I think this could be used then in strategies or bids that we are putting in.” (Local Authority Manager 3)
However it was much harder to make service recommendations, especially for front line professionals unfamiliar with commissioning

“My feeling is that sometimes there can be a lot of discussions and then constructively nothing may be happening” (Local Authority Representative 1)
Service utilisation & costs

- Practice nurse consultations were higher at 3 months, but by 6 months were lower than baseline.
- GP consultations were unchanged.
- No significant difference in use of any non-NHS services
- No significant change in NHS costs at 6 months compared to baseline
  - Median £144/patient for last 3 months at baseline, £139/patient for last 3 months at 6 months.
Service utilisation & costs

Intervention costs:

- £125 per practice set up costs, then **£4.68 per older person invited** (with 30% response).
  - Includes costs postal questionnaire, report generation & checking, review of reports and follow-up by nurse or GP in 20%.
  - Excludes local adaption of software (approx. 1 week administrator time).
Key messages
In summary

- DH wants more pro-active health promotion for older people.
- ‘Population scanning’ using a comprehensive postal questionnaire is one approach, that can be automated so a tailored report is generated.
- Using this approach, with active follow-up of new complex needs appeared feasible for General Practices.
- Professionals were able to discuss needs of the local population.
- Data generated from the MRAO could be used assist Health and Wellbeing boards to identify unmet needs and promote healthy ageing.
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• **Disclaimer:** The views expressed are those of the authors and not necessarily those of the funder. For further information contact Melanie Handley, m.j.handley@herts.ac.uk
References


